Special Commission on the Health Care Payment System
Commission Meeting Minutes
February 24, 2009

Meeting Date, Time, and Location

Date: Friday, February 24, 2009
Time: 2:00pm – 3:00 pm
Place: One Ashburton Place, Boston

Meeting Attendees

Commission Members	Speakers	Contractors and Support Staff
✓ Leslie Kirwan (co-chair) ✓ Sarah Iselin (co-chair) ✓ Alice Coombs, MD ✓ Andrew Dreyfus ✓ Deborah C. Enos ✓ Nancy Kane ✓ Dolores Mitchell ✓ Caroline Fisher, attending on behalf of Richard T. Moore ✓ Lynn Nicholas ✓ Melissa Thuma, attending on behalf of Harriett Stanley	✓ Michael Bailit, Bailit Health Purchasing ✓ Harold Miller, President and CEO, Network for Regional Healthcare Improvement and Executive Director, Center for Healthcare Quality and Payment Reform ✓ Glen Hackbarth, Chair of Medicare Payment Advisory Commission	✓ Michael Bailit, Bailit Health Purchasing ✓ Bob Schmitz, Mathematica Policy Research, Inc. ✓ Margaret Houy, Bailit Health Purchasing, LLC ✓ Seena Carrington, MA DHCFP

Meeting Minutes

I. Welcome and Overview

Co-Chair Leslie Kirwan introduced Caroline Fisher, attending on behalf of Senator Moore, and Melissa Thuma, attending on behalf of Representative Stanley. Ms. Kirwan explained that this is the third in a series of educational meetings, which will focus on episode-of-care reimbursement and evidence-based purchasing. Harold Miller will be participating in person and Glenn Hackbarth will be joining the Commission via phone.

Co-Chair Sarah Iselin reminded the attendees that the March 13 meeting will run from 11am to 2pm and to bring lunch. That meeting will focus on global payment and global budgeting. Ann Robinow from Minnesota, founder of Patient's Choice, and a representative from BCBSMA will be presenting case studies on global payment. Materials will be sent out in advance, including a whitepaper on global payment and one on the non-payment models mandated in the statute (e.g., tiering benefits, evidence-based coverage).

II. Report on stakeholder meetings – Michael Bailit, Bailit Health Purchasing

Michael Bailit reported that since the last Commission meeting he has met with 12 employers and employer representatives to discuss the Commission's list of principles. The two key messages from the employers are:

- The objective of cost containment needs to be explicitly stated in the principles, and
- The role of the employers needs to be incorporated into the Principles.

Michael will be incorporating the employers' ideas, as well as ideas from the other stakeholders and circulating the revised Statement of Principles to the Commissioners. He noted that the principles have gotten longer with the stakeholder input, and asked the Commissioners to carefully review the list to determine if they are too long. He expects to distribute the revised principles on Wednesday to the Commissioners.

Commissioners' Questions and Comments

Question and Comments	Speaker's Response
What did the employers mean by asking that cost containment be more explicit in the principles?	The principles need to clearly state that payment reform is a goal of cost containment.
As the principles have expanded, are they internally inconsistent? If so, is more time needed to resolve these inconsistencies?	There are internal tensions, but they were there before the principles went out to the stakeholders.

III. Overview of episode-based payment models – Harold Miller

Mr. Miller provided a conceptual framework for considering episode-based payment models. The health care cost equation considers the

- number of conditions per person,
- the number of episodes of care per condition,
- the types of services provided per episode of care,
- the number of processes per service and
- the cost per process.

Currently fee for service (FFS) captures only 2 of the cost variables: the number of processes provided and the cost of the processes. There are no limits on the number of services offered. Under FFS some services are not reimbursed and not all processes are provided for each patient.

Payers have added utilization review and pay-for-performance to make sure all appropriate processes are done for each patient.

Under the other extreme, which is traditional capitation, everything is covered under a fixed price. The problem with this approach is that the provider is at risk for treating sicker patients (the insurance risk) as well as for what services are provided (performance risk). The provider is assuming both the insurance risk and the performance risk.

Episode-of-care payment models pay based on episodes. Under this model, offering too many services is not a problem and providers have the flexibility to decide what services to provide. Outcome monitoring provides incentives for providers to provide the right services. There are still no limits on the number of episodes. The response is to offer a condition-adjusted capitation or risk adjusted global fee.

Episode-based payment systems are applicable to different kinds of conditions:

- minor acute conditions, the episode of which is based on the resolution of the minor acute condition;
- Major acute conditions, the episode of which is based around the resolution of the major acute condition or a typical window of time, and
- Chronic conditions, the episode of which is based on resolution of the exacerbation of the chronic condition symptoms or an arbitrary period of time.

Episodes have two dimensions: 1) the length of time to cover a condition and 2) the providers and services to be included.

An example of the components of a major acute episode is as follows:

- Length of time: pre-admission, hospitalization, post-acute care and readmissions within a specified time post discharge, and
- Providers: physicians, devices and equipment, drugs, non-MD staff and facility costs.

There are five possible stages to transition to a comprehensive episode-of-care payment system:

- Create a case rate for each provider in each phase of an episode of care (e.g., pay each physician a single fee for a patient's hospital stay).
- Include a warranty in each provider's case rate (e.g., include the cost of any related hospital readmission in the hospital's DRG payment).
- Bundle case rates for all providers in a particular phase of an episode of care (e.g., pay a single fee to both the hospital and physicians managing the hospital stay).
- Bundle rates with warranties (e.g., pay a single fee to the hospital and physicians, covering the initial admission and readmissions.)
- Combine the case rates for all phases of an episode (e.g., pay a single fee for both inpatient and post-acute care)

CMS is bundling hospital costs and surgeon fees for case rates in pilots.

Severity adjustment is essential to episode-based payments. FFS implicitly adjusts for patient severity. There are two types of adjustments – ones based on clinical categories, and ones that are regression based. There is a debate as to which is better.

Using episode-of-care payments for chronic conditions has specific challenges. A hospitalization for a chronic disease exacerbation could be treated as an episode, and paid for in the same way as a hospitalization for an isolated acute episode. However, because hospitalization can be prevented, it makes more sense to think of a chronic condition episode as a fixed period of time. Think of the hospitalization as an avoidable service during that period of time.

Setting the price of an episode of care can be done by: regulation (ie. Medicare); by negotiation (i.e., commercial insurers), or by competition. There is no mechanism to steer the patient to the lower cost provider. Moreover, the consumer's share of the cost is the same regardless of provider selected or actual cost. The alternative is to have the consumer pay the last dollar of the price, rather than the first dollar. The problem is that patients do not know the price differential going in. Some websites are being developed. See Carol.com.

Do episode of care payment systems need to be implemented on an all or nothing basis? When using episode payments to achieve specific goals, you need to consider the goals to decide on what type of episode-based payment is best. If the goal is to:

- give providers flexibility to decide what services to offer beyond FFS codes, then pay a provider a fixed amount during his/her portion of an episode.
- control over utilization of services and/or providers within an episode, then pay a fixed rate for all services controlled by a provider.
- coordinate provider decisions about care, then bundle payments for the providers together.
- facilitate consumer choice of lower-cost providers/services, then define a single price for an entire episode and differentiate co-insurance amounts.

If you want to use other approaches to achieving the goals, there are other payment approaches that can be used. If the goal is to:

- give providers flexibility to decide what services to offer beyond FFS codes, then authorize additional FFS codes or an "all other" fee (e.g., care management fee).
- control over-utilization of services and/or providers within an episode, then use P4P incentives based on retrospective episode profiling.
- coordinate provider decisions about care, then facilitate gain-sharing arrangements.
- facilitate consumer choice of lower-cost providers/services, then use retrospective episode profiling of providers plus differential co-insurance amounts.

Other models can also be integrated. Pick areas where the goals need to be met and apply an appropriate model. For example if the goal is provider flexibility, consider the medical home. If the goal is consumer choice, certain types of surgeries lend themselves to consumer price comparisons.

If episodes-of-care payments are to be implemented on a partial basis, you need clinically distinct conditions. When dealing with a condition with co-morbidities, it can become complicated. Should the episode condition be diabetes, COPD, or diabetes plus COPD? Is a global fee better for conditions with co-morbidities? No one knows the answer because no one has done this yet.

It is possible to combine capitation with episode payments. There could be a global fee for a particular condition with the outpatient care based on a medical home model and any hospitalizations paid on an episode basis.

Other implementation issues relate to who gets the episode payment and are new billing and payment systems needed. If the providers are an integrated system, the system can accept payment and divide it internally. Joint ventures, such as PHOs, can be formed to accept and

divide payments. The payer could pay each provider directly according to pre-determined rules, a form of 'virtual bundling." It is possible to base episode payment on existing FFS billing systems. These systems can adjust fee levels or pay bonuses to reconcile total billings against prospectively defined payments. There may be a need for new fee codes for currently unpaid services.

Since episode-based payments provide incentives to provide fewer services or poorer quality care to a patient, there must be public reporting on quality of care measures. The system must also ensure that bad outcomes are included in the episode and add pay-for-performance quality incentives for things not captured in the episode.

Successful implementation requires that all payers are involved. There is a need to think about improved payment systems and restructured delivery systems simultaneously.

Episode payments have been tried several places and they have worked.

- In 1987, an orthopedic surgeon in Lansing, Michigan worked out a fixed total price for surgical services for shoulder and knee problems. A study found that the payer paid 40% less than it would otherwise, and the surgeon received over 80% more than otherwise.
- In 1991 CMS did a demonstration project for heart bypass surgery. Each of four hospitals received a single payment covering both Part A and Part B services for CABG, with no outlier payments permitted. Hospital and physicians were free to split the combined payment. The results indicated that physicians identified ways to reduce length of stay and unnecessary hospital costs; costs decreased between 2% to 23%; post-discharge outpatient expenses decreased and patients preferred the single co-pay.

Currently there are a few episode-of-care initiatives:

- There is a Medicare acute care episode demonstration in which CMS will pay a single amount to cover both hospital and physician services for cardiac and orthopedic surgeries;
- Geisinger offers a warranty that covers any follow-up care needed for avoidable complications. Geisinger is an integrated system and the only plan paying on this basis is the Geisinger Health plan.
- Prometheus Payment covers full episodes of care and all providers associated with the episode. It uses a combination of historical costs and evidence-based information to set payment levels. Prometheus estimates that overall 53% of costs are associated with potentially avoidable complications. More money could be saved in treating CHF, diabetes and COPD, than in treating conditions, such as hip and knee replacements, that require surgeries.
- Minnesota is phasing in episode-based payment, which it calls "baskets of care". The state is currently defining baskets of care for episodic payments. By 2010 providers may voluntarily establish package prices for the baskets of care. Providers must accept the same fee from all payers.

Mr. Miller offered the following concluding thoughts:

- Think about the types of episodes with a large volume of cases and potentially large savings;
- Develop common definitions of episodes;
- Use a severity adjustment;

- Start reporting on the basis of episodes, but continue to pay FFS. The reporting must be public.
- Provide technical assistance to providers to reduce costs;
- Implement software enhancements that can distinguish which claims are to be paid on a episode basis and which not, and
- All payers need to agree to pay in this manner for the episodes identified.

Commissioners' Questions and Comments:

Question and Comments	Speaker's Response
Can costs associated with end of life care be handled as an episode? Hospitals see this as an area where there is a great deal of futile care being provided.	I think you can, but not much work has been done on this issue. You can think of the chronic condition population and factor in end of life costs, or you can think of end of life as a separate episode and how to manage it. The CMS hospice care uses time to demark end-of-life. You must get physicians willing to tell people that they are going to die. Currently there is no incentive not to give the last round of chemotherapy.
You identified three types of episodes (minor acute, major acute, and chronic). Where do most of the dollars fall for people under age 65?	They fall between major acute and chronic conditions. There are lots of labor and delivery costs in that age group.
Where would behavioral health costs fall?	The question is whether it is co-morbid or a single diagnosis. In Pennsylvania we looked at readmissions data, and depression was one of the top 4 diagnoses. Prometheus has found the top diagnoses to be CHF, CODP, diabetes and depression in the under 65 commercial data bases.
When considering who get the payments, what is the breakdown of dollars?	It depends on the geographic area. If you are talking about major acute episode, it varies dramatically across the country. In some areas physicians and hospitals are at odds, in other areas PHOs work well together. Maybe it makes sense to start with someone who will take the dollars and let others see that it works.
We are gathering some baseline data around where dollars are spent and organizational structures.	When thinking about readmissions, ask who is responsible. If it is for an acute episode, the readmission is probably driven by how the hospital did or did not manage the transition. For chronic conditions, readmissions are probably based on something going wrong in the community.
We need to do some homework around	

Question and Comments	Speaker's Response
inventorying relationships between hospitals and providers and asking is it a real PHO with collaboration.	
Is there any experience with partial implementation and monitoring of total costs? Are cost savings sustainable across the entire system?	There have not been enough studies done to give a definitive answer. In the 1990s CMS did a demonstration around cardiac surgery, which only bundled hospital and physician costs. CMS did not see any costs being pushed to post-hospitalization services to make more money. This is only one study, involving only acute episodes of care. The real risk is with chronic conditions.
When one is combining global fees and episodes of care, it opens a gap that could result in more payments. You never mention health plans until the end of your presentation. Our task will be to talk with lawyers regarding how to do this and avoid anti-trust issues.	There is a legal exemption where the state is involved. Minnesota came up with a system, asked for comments from payers, and then each payer individually could accept or not.
With a condition-adjusted capitation, there is no incentive to control the volume of care. This is compounded by the differences between acute and chronic care. There are different incentives if back pain is treated as an acute or a chronic condition.	Go back to the goals. If the problem is over utilization of back surgery, episode-based payments for back surgery is no solution. If you think the need is to have hospitals and physicians work together to get cheaper back surgeries, then an episode payment involving both hospital and provider services will work. The problem is if the cost of the surgeries declines, how to you get the savings back to the employers paying for the coverage. If you are treating back pain as a chronic condition, then move bundling to earlier in the process to control use of back surgery and use of MRI. You could do a partial model with the physician responsible for 10% of the cost of hospitalizations.
Where is Minnesota in implementing their episode of care system?	I suggest that you go on the Minnesota Department of Health website. I think they will focus on major acute episodes because some providers already want to do this and compete on prices. Minnesota has lots of history of patients choosing providers based on price.
Why would physicians want to compete on price?	Consumers will switch when prices are different. Providers will find a way to lower costs. The problem will be lack of patient volume to get providers to respond. The

Question and Comments	Speaker's Response
	BHCAG (Buyers Healthcare Action Group) system included both an episode payment and a global fee structure. The Minnesota legislature passed only the episode piece, but not the global fee structure.
Minnesota is hugely integrated with few stand-alone hospitals and almost no solo physician practices. This is a very different structure from Massachusetts.	
We tried very hard to get Patient Choice adopted in Massachusetts and no one would go for it. (NOTE: Patient Choice was a program developed by the Minnesota BHCAG which featured global and episode payments for providers and patients choice of providers based on cost of services.)	
Physicians are concerned about the relative weight of payment for services.	You are raising two separate issues. Under a severity adjustment, you must assure that you have properly adjusted for different patients. The other issue is whether the episode is priced properly. Medicare says this is what you will be paid. The question is how to set prices. You can't compete on price for rate services using a market-based system.

IV. Case Study of Episode-Based Payment – Glenn Hackbarth

Mr. Hackbarth opened his presentation with statements of congratulations to Massachusetts for implementing its universal health care initiative. He expressed the sentiment that people in Washington, DC want Massachusetts to succeed. He encouraged the Commonwealth to develop new payment systems and seek a Medicare waiver to support the effort, but warned that additional funds are not likely to be available.

Mr. Hackbarth offered the following observations about episode-of-payment models:

- Episode-based payments offer a possible benefit, but are not the sole solution.
- Hospital-based episode-based payments are an easier target than ambulatory episodes. Ambulatory payments are important, but more complex and challenging, than paying episodes around a hospital admission. Med PAC does not pretend to know how to do hospital-based episode payments. We are recommending that CMS start with a pilot project to work thought the operational issues.
- Med PAC's responsibility is conceptual and directional. The operational responsibilities are with CMS, which has staff and technical capabilities to engage with health care providers to design and implement a new system of payments.
- You need to advance in stages. First pilot different forms of payment. Once you get to a preferred form, then you need to disclose to hospitals how they are doing with defined

episodes and associated costs. Hospitals have not focused on episodes of care. Physicians may not know readmission rates for COPD, for example.

- Focus on episodes that have large volume.
- The state of readiness of providers to accept episode payments will vary based on their ability to coordinate, share and allocate resources. Medicare payments have not encouraged this type of collaboration; rather Medicare has encouraged maximizing income within ones own silo. We need to change focus, but that won't be easy. Hospitals see physicians as almost unmanageable, and physicians view hospitals as unresponsive and too powerful. Past efforts to breakdown barriers have not been that successful. The inertia in the system is considerable.
- Implementation of a new payment system must be on a voluntary basis.
- In considering what to do with those who do not volunteer, you cannot leave the status quo so comfortable that they won't change. For those who do not volunteer, you need to exert pressure/discomfort to incent change of the old ways. This could be in the form of a penalty for excess hospital readmissions. It could be a carrot approach with Medicare gainsharing with hospitals and providers. It is currently difficult for hospitals and physicians to share rewards. Gainsharing could only be under certain conditions to protect against abuse and to create conditions for constructive dialog between physicians and hospitals.
- One of the basic rules for obtaining a Medicare waiver is that it is budget neutral for the Federal government. Determining budget neutrality is both an art and political. With the retirement of baby boomers and the current economic crisis, there is an increase in federal obligations which is unsustainable. The environment in which Massachusetts seeks a waiver may be more demanding than in the past.

Mr. Hackbarth identified additional changes that must be done simultaneously to bring about needed change:

- Significantly change the payment system to increase payments for PCP services. This is very important in the management of chronic illness and is easier to do than episode-based payments.
- Immediately begin feeding back to physicians and hospitals information on episodes-of-care by comparing patterns of practice with peers.
- Medicare is investigating the idea of paying on the basis of Accountable Care Organizations. (Eliot Fisher has written on this topic. See the current edition of *Health Affairs*.) CMS would continue to pay providers on a FFS basis, but create opportunities for organizations to share in savings. Performance would be measured on total cost of care (ambulatory, acute and chronic), including all types of providers. Patients would have a free choice of providers. Whether this can be operationalized is still open to question.

Commissioner Questions and Comments:

Question and Comments	**Speaker's Response**
What is CMS' timeline for moving to episode-based payments and deciding whether it moves beyond a volunteer basis?	I could imagine moving beyond a voluntary basis once we have worked out the bugs and some provider organizations have had success. Other providers need to say "I want some of that and I have a template for how to do this." The timeline to move to a broad based

Question and Comments	Speaker's Response
	implementation is a function of political acceptance, which requires legislative change. The other big barrier is operational and CMS' capabilities. CMS is much maligned and has an impossible job because they are asked to do complicated things with too few resources. Congress could accelerate the adoption by increasing investment in CMS operational capabilities, but it has not been willing to do so. I am hesitant to give a timeline. It will take a number of years (3 to 5 years) to implement episode-based payments on a wide-scale, voluntary basis.
There are other types of incentives to encourage provider organizations to create more integrated systems, such as leaving the Sustainable Growth Rate (SGR) system in place. NOTE: SGR is a mechanism created by Congress in the 1900s that currently is applying pressure on Medicare physician fees. When the growth in physician services is greater than GDP, rates need to decline. Congress has moderated the impact of SGR annually. To meet SGR targets next year, rates would need to be cut 21%, which Congress won't let happen.	There are other incentives besides SGR. If you want to change the payment system and need the active participation of providers, you need to make the status quo uncomfortable. Some people think SGR can be the pressure to change payment methodologies, particularly in the context of Accountable Care Organizations (ACOs). For physicians and hospitals wanting to be ACOs, the incentive is an alternative payment system, which lets physicians get out from under SGR.
With hospital margins low, there is an increasing appetite to do something new and better. Is there an opportunity for CMS to work with providers on a state-wide basis to do a demonstration in which we can find incentives that will encourage everyone to join?	In the last several years hospitals have had high margins across all payers, and this did not lead to daring innovation. The evidence seems to be to remain comfortable, not change. More dollars do not lead to more innovation. Any reward for innovation must be targeted and precise.
The big inequities in payments to hospitals are on the private side, so it is hard for all hospitals to have enough funds to innovate. We need to think about leveling the playing field in terms of commercial payers. Don't pay one hospital more than another because of market clout.	The other debate in Washington is about universal coverage. To the extent that Washington spends more money, it will be for universal coverage. The quid pro quo for providers is to reduce the burdens of uncompensated care through universal coverage. In terms of payment policy, we will demand more of providers, not less.
On one of your slides you say, "CMS cannot designate efficient providers." Transparency does not prohibit patients from going to inefficient providers. Is there any change in the	Release of information will not conflict with the freedom of choice provision in the Medicare law. What would violate the law is if CMS tries to limit choice to certain groups of

Question and Comments	Speaker's Response
gag law not to release data?	providers. Even a PPO would require legislation. Then the question is political and it is very difficult to get people to embrace this concept because it prompts constituent reactions to protect their local provider from being excluded for a Medicare network. With regard to the litigation in which CMS was found to not have the authority to release CMS data to a private organization, Med PAC will be making a recommendation to Congress to allow the release of the data.
In the previous presentation Mr. Miller contrasted episodes to risk-adjusted capitation. Are there other more effective models?	Disease-based ambulatory payment is appealing. The problem is the lack of organizational infrastructure to receive global payments. Some organizations, such as Harvard Vanguard, are available, but they are the exception, not the norm.
BCBSMA is seeing increased interest of hospitals, and other providers in joining PHOs to experiment because they see this is the future of reform. In the last 6 to 9 months, we have seen higher enthusiasm to accept alternative payment models. I am encouraged in seeing providers more open to different types of payments.	In terms of the dynamics of payment reform, ideally we are doing complementary things. Ambulatory episodes may be more viable in different markets. There may be a ripe opportunity for private health plans to go after this type of change, rather than Medicare. Medicare Advantage is its way to allow different opportunities to try different payment models. The problem is that the benchmarks are set in a way to undermine Medicare Advantage as a tool for innovation.
At least we know from Medicare Advantage that when CMS pays capitation to a specific organization, consumers will accept restricted choice. Even then, you need a large geographic area to figure out capitation. It is hard to set the capitation rate: if it is too low, plans drop out; if it is too high, there are no cost savings.	

V. <u>Overview of Evidence-Based Purchasing</u> – Michael Bailit

Mr. Bailit reminded the Commission that evidence-based purchasing is not a payment model, but it is part of the Commission's mandate. It can work in support of a payment model to reduce costs for unnecessary or less valuable services. The Commission will have background papers available on several non-payment models in the future.

Mr. Bailit presented the following information on evidence-based purchasing (EVP):

- The context for EVP is that experts estimate that between 25% and 50% of health care expenditures produce no patient benefit and can create harm. Researchers have shown that in Medicare there is an inverse relationship between health care spending and health care quality.
- EVP uses research evidence to decide what to cover. Currently the issue is the degree to which evidence is being used to make coverage decisions. Currently its application is not sufficient to limit waste.
- Barriers to using evidence to make coverage decisions are:
    - FFS financial incentives;
    - Supply-induced demand
    - Patient advocacy
    - Professional mission
    - Lack of information about what works and if it works, is it more effective than something else.
- Effectiveness research is being done in the US by AHRQ-supported practice centers, by state initiatives including Medicaid initiatives, and by health care technology assessment vendors. The 2009 Economic Stimulus Package includes $1.1 billion in federal funding to investigate how different treatments compare in effectiveness. However, lobbyists pressed to include language in the bill's conference report saying Congress doesn't intent for Medicare or other "public or private payers" to use the research to make coverage decisions.
- Other countries have done more in this area than the US. The National Institute for Health and Clinical Effective evaluates the cost and effectiveness of treatments and guides coverage policy for England's National Health Service. Similar organizations exist in France, Denmark and Germany. The UK's Cochrane Collaboration is a private effort that serves a similar function but does not advise the government.
- Evidence of effectiveness can be applied in five different ways:
    - Exclude coverage of services of no value;
    - Exclude coverage of services of low priority/low value (Oregon uses this approach);
    - Limit coverage of service to only those clinical applications were evidence of effectiveness exists;
    - Limit coverage to services that produce the highest value when considering both clinical effectiveness and cost (Medicare is prohibited from doing this, but it is often done in establishing commercial insurers' drug formularies.)
    - Limit coverage of services so that higher value options are attempted before lower value options are covered (stepped approach).
- Evidence is also used in Value-based Insurance (Benefit) Design by varying the cost-sharing to provide incentives for patients to use a) high value services and/or b) providers with demonstrated superior effectiveness.
- Washington state's Medicaid program has created a grading system for evidence of effectiveness:
    - A = evidence is based on randomized controlled clinical trials
    - B = evidence is based on consistent and well-done observational studies
    - C = evidence is based on inconsistent studies

  - D = studies show no evidence of effectiveness, raise safety concerns, or document no support by expert opinion
- Washington generally approves A and B services for coverage. C and D services are approved only upon special case-specific review.
- Washington reduced spending for bariatric surgery from $970,000 in 2003 to $56,000 in 2006; realized a $10 million saving in enteral nutrition spending, and reduced ADD drug spending for children through required second opinions and realized a 3:1 return on investment.

Mr. Bailit offered the following concluding thoughts:

- Evidence is not used in purchasing to the extent that it could. For example, Wellpoint, a large national insurer, has only 20 FTEs involved in this activity.
- There are real challenges to the application of evidence.
- EBP can serve to complement payment reform. It would require state-wide, all payer participation.

Commissioner Questions and Comments:

Question and Comments	Speaker's Response
EOHHS has been challenged with looking at studying the ability to establish a regional comparative effectiveness organization.	
If the federal government is setting up one and sending out dollars regionally, I don't know why Massachusetts would want one too.	
This issue on the federal level provokes fear and lobbying. I recommend that those in the state look at just starting with 3 or 4 high cost interventions were evidence of benefit is questionable and where practice varies widely. There is a local evidence-based organization here in Boston. If physicians could be comfortable using this in certain areas, it would make it easier in the future.	Washington state started with services that showed patient harm.
Everyone would benefit from evidence-based service information. If we could get this rolling, it could be a big help.	
If we could find 4 or 5 areas, there is a benefit of starting on a small scale with uniformity. We could manage consumer response and protect each plan's competitive advantage.	
Hospitals are doing things because hospitals down the street are doing them. Maybe we need to do something with what we already have, rather than studying this.	
It would be interesting to know who is funding	

Question and Comments	Speaker's Response
consumers who are complaining; often it is the manufacturer of the equipment being evaluated. Maybe we need disclosure of who is funding the advocates.	

Leslie Kirwan closed the meeting by summarizing the hurdles to implementing episode-based payments:

- Institutional readiness;
- Definition of episode;
- Gaps and how to handle them so costs do not appear somewhere else;
- Role of the consumer and how to enhance that role;
- The spectrum of voluntarily implementing the payments: looking at carrots and sticks compared to how long it will take to get this done, and
- For those who cannot move to innovation, what is the default position?

Sarah Iselin added that during the Commission's 6th meeting (the one after next), the Commission will be looking at what is its vision and how do we get there. The Commission will wrestle with the issues its members started to discuss today.

The meeting ended at 4:45pm.